Meeting Minutes of
The Governor's Council on Behavioral Health
1:00 P.M., Tuesday, May 8, 2007

The Governor's Council on Behavioral Health met at 1:00 p.m. on Tuesday, May 8, 2007, in Barry Hall's Conference Room 126, 14 Harrington Road, Cranston, Rhode Island.

Members Present: Richard Leclerc, Chair; Linda Bryan; Elizabeth Earls; Sandra DelSesto; Mark Fields; Wendy Looker for James Gillen; Mitch Henderson; Richard Hill; Joseph Le; Peter Mendoza; Noreen Shawcross; Neil Corkery; and Reed Cosper.

Ex-Officio
Members Present: Craig Stenning and Gene Nadeau, Department of Mental Health, Retardation and Hospitals (MHRH); Jane Anderson, Jeanne Smith, and Sandy Woods, Department of Children, Youth and Families (DCYF); Elizabeth Gilheeney, Department of Justice; Denise Achin, Department of Education; and John Young, Ellen Mauro, Debra Florio, and Alicine Crooke, Department of Human Services.

Staff: Corinna Roy, Charles Williams, Kristen Quinlan, Mary Ann Nassa, Ron Tremper, and Elena Nicolella.

Once a quorum was established, the Chair, Richard Leclerc, called the meeting to order at 1:05 p.m. After introductions were conducted, Richard entertained a motion to accept the Minutes of April 12, 2007. Neil Corkery motioned to accept the minutes and Peter Mendoza seconded the motion. All were in favor, and the minutes were approved as written and submitted.

MEDICAID MANAGED CARE SERVICES FOR ADULTS WITH DISABILITIES: FY08 PLAN

Richard introduced John Young, Deputy Director of the Department of Human Services (DHS). John distributed the ***Program Update - Managed Care Options for Medicaid Adults in Rhode Island as of May 8, 2007 (See Attachment I).***

John Young reviewed the history of the program. The advocacy for the legislation (Senate Bill 801/House Bill 5734) that set the path in July of 2005 was sponsored by the Governor's Commission on Disabilities. Over 27 community forums were conducted from December 2005 to the present. John described multiple populations of folks in those forums that align themselves around their disability which influences how they come to the table. In April of 2006 a report was submitted to the legislature regarding the program's design. John stated that the plan will not resemble a conventional commercial plan of coverage. The Federal government has created two classes of beneficiaries – some who are fully eligible for Medicaid and only eligible for Medicaid and some who are also eligible for Medicare. This has created the question of what is the interplay between all of those populations.

John referred to the slide on Page 2 of Attachment I, ***Who is the Population***. In Fiscal Year 2005 there were 43,363 adults below the age of 65 in the program on Medicaid because of a disability. Of those 43,363, there were 7,648 individuals living in nursing homes who are less susceptible to intervention than those living in the community because most of their care is provided in the institution and most, if not all, are dually eligible for Medicare. There are 35,725 individuals living in the community – i.e., living in their own home, living in subsidized housing, assisted living, group homes, etc.—in a variety of places that are not federally defined as institutions. Of those 35,725 individuals, 20,777 are dually eligible for Medicare and 14,948 individuals who are not eligible for Medicare. They are living in the community and are the population that they would like to put together a set of benefits and services that would accommodate their needs. However, there are folks that are served as priority populations by MHRH and that means that they are severely and persistently mentally ill (SPMI) or they are enrolled in the MR/DD Waiver. Therefore,

there is approximately 12,048 people who are not part of the priority populations of MHRH, that are primarily served by services that DHS pays for – i.e., their primary and acute care, their prescription coverage, behavioral health (if they can get it), and home and community-based waiver services, which includes personal care and durable medical equipment.

Craig Stenning added that there are individuals who are considered part of the MHRH core populations who are not included in the above mentioned numbers who have significant substance abuse problems. John agreed and stated that the main reason that they are not subdivided out is that when discussing eligibility categories, SPMI and DD are not eligibility categories. Therefore, there is not a unique identifier in any of the systems and there is an assumption that they are within these groupings largely by the types of services they are receiving. Additionally, substance abuse tends to be something of a mixed bag. John stated that it is not perfect and that is part of the limiting factor to their ability to make that cut.

John stated that the target population that they are considering for the initial offering of a Managed Care Option or set of options is the 12,048 people identified above. He stated that because of the broad set of diagnostics that are being dealt with and the fairly broad set of living arrangements that people have, it is difficult to figure out whether or not the package they have designed is fully appropriate; therefore, they attempted to listen carefully to what people had said. He highlighted the following feedback from the community forums:

- Some of the benefits are difficult to access
    - Transportation
    - DME
    - Dental --John stated that access to oral health is severely limited to individuals on Medicaid.
- They would like more flexibility in what benefits are covered
- Lack of access to behavioral health care
- Lack of network/access to physicians
- System of care is fragmented, and
- Coordination of services is needed.

John stated that it is a matter of who you are listening to, what their experience has been and what their perception of what their experience has been, which can lead to a conclusion that is not necessarily valid that this is widespread, statewide, and pervasive. He does not believe it is so because of the organized system that is available, but it is not designed or funded to be a universal solution for everyone. John also stated that many of these folks have problems accessing physicians' and specialists' care. In general, the system of care is fragmented.

John acknowledged general opinion that the physicians' system of care in Rhode Island is not necessarily properly arranged to accomplish all of the goals that they are identifying for this population. Physicians do not necessarily communicate in an open and collaborative fashion, they are not linked electronically, and the limits of their knowledge about any particular case are what are told to them by the patient and what they can learn from test results. Therefore, another option needs to be made available for folks who may not immediately be able to benefit from the full advantage of a health plan benefit, but need something more than they have.

John referred to the slide on Page 3 of Attachment I, ***Managed Care Delivery System Options.*** He described Connect Care Choice which has been a fairly small coordinated care, disease management, nurse case management program for several years that is a very intensive care coordination model and has been very successful in helping reduce hospitalization and improving people's general health status. With a current enrollment of approximately 240 individuals, it is a labor-intensive effort, it is resource heavy, and it is somewhat limited in scope; but it has been able to assist several hundred people to improve health

status and access health care over its life. Therefore, in addition to Rhody Health Partners, Connect Care Choice is a primary care case management, care coordination program that looks at an enhanced practice model so that the physician who is intervening in the case and treating the client has more knowledge than they otherwise would have and would have a broader ability to manage the overall health portfolio. John stated that at some point these two models will have a stronger overlap. The style of care with Connect Care Choice will influence the style of care that is available with Rhody Health Partners.

John referred to the slide on Page 4 of Attachment I, ***2 Phases of Rhody Health Partners.*** He stated that the theme is a matter of choice and options so that people can accommodate their interests and needs with a product that best suits them. Their selection should be driven by choice even with a "mandatory" enrollment.

The rollout consists of a voluntary opt-out system – i.e., progressively, people in the target population will get a letter from DHS stating something like "Congratulations, the Department of Human Services has developed two new programs for your selection and here is what they are about…., and we are asking you to make a selection, and if after a reasonable period of time you have not, we may help you make a selection, and you may disenroll at any time." The mailing will start some time during the summer of 2007 and begin to team up people with either a plan or a physician practice. With Connect Care Choice there is a series of physician practices that they are working on because they have already attracted a significant Medicaid population and may have an interest in becoming Connect Care Choice providers.

Based on discussions with MHRH, a letter will not be sent to individuals who are accessing services within MHRH. It is an assertively voluntary system. Reed Cosper asked if John could explain "disenroll." John stated it could mean existing status or switching to another option. He explained that a large portion of hospital expense in Medicaid is fueled by untreated behavioral health issues, and many of those individuals consuming those services are not in the MHRH population.

John referred to the slide on Page 5 of Attachment I, ***Rhody Health Partners Benefit Design.*** He stated that the Federal Authority allows DHS to offer state-plan services through the health plan, and not additional services. Nursing home stays are an in-plan benefit, up to 100 consecutive days. John stated that many individuals in the waiver programs are there for support, and support is not a conventional treatment but should be part of the arsenal to be used to get people to the most appropriate, least intensive, most natural setting for care.

Craig Stenning stated that traditionally managed care does not do well with certain types of support that are offered in the Behavioral Health system – i.e., residential care, methadone maintenance, and limits on outpatient. Craig was concerned about choice and when someone opts-out. If they receive the letter and do nothing in response, will they be enrolled? John stated yes. Craig expressed that this population may not cooperate with making those kinds of choices, and especially the drug-treatment population that tend to be suspicious of government entities because of their involvement with activities that were not legal.

John stated that the consequences of not making a choice will assume that their choice would have been Rhody Health Partners. If they decide differently subsequent to that decision, they will have an option to come out of Rhode Health Partners. John stated that the current approach is an open-ended opting out.

Neil Corkery asked when the mandated discussions between the current provider organizations and new plans would take place. John stated that those discussions would take place before the letter.

Richard Leclerc asked if it is part of the plan to do an adequate amount of specific education of providers in the network in order for them to properly address the clients. John stated yes that it would be part of the rollout plan.

Reed Cosper inquired about the dually eligible. John explained that people who are dually eligible for Medicare are getting their primary medical coverage through Medicare Part A, Part B, Part C, and now Part D; and those are all different delivery system options that are available to them, not Medicaid. Those individuals are not part of the target population because that coverage would be duplicated.

The question of if there would be a change in the billing software was asked. John stated that there would not be any change in the billing software.

Richard Leclerc asked if some one who is SPMI gets a letter and decides to sign up for Rhody Health Partners A, is it valid. John stated because there is not a clear identity in the system as to who those folks are, if they act on it, and make a choice, their choice will be supported. John stated that as they proceed, it is important that they become more descriptive about who is in what program.

There was no further discussion, and Richard thanked John Young and his staff for taking the time and presenting the Council with this information.

UPDATES FROM MHRH

Craig Stenning reported that MHRH and DCYF are working closely together at a variety of levels regarding the proposal to assume a portion of the 18-21 year olds who will be transferred out of the DCYF system into MHRH. It is still before the General Assembly, and as soon as a decision is made, the Departments are prepared to implement their resolution immediately.

The contract to provide an integrated system of inpatient psychiatric and detoxification services for the uninsured indigent population has been signed, and the Purchasing Office for the State has issued a final award and that system will go into place on Monday, June 4, 2007. Anyone in the current system as of that date will continue in that system and will be paid for by MHRH.

Craig reported that MHRH staff is in the process of preparing an application for the Access to Recovery Program. Craig introduced Charles Williams to give an overview. Charles stated that there was an initial round of awards in 2004, and in the second round there will be 18 awards and previous award winners are eligible to compete in this go-round. It is a consumer focused and driven program which entails issuing vouchers to individual consumers and insuring that they have a choice of at least two service options, including one to which they have no objection. It covers recovery support services from psycho-educational groups to educational support for child care depending on its configuration, and a range of clinical treatment services. It involves an initial screening to determine eligibility and then an assessment for definitive level of care. Up to 15 percent of the award can be used for administrative services, and screening is considered an administrative service, therefore, there will be screen components as well as on program plan administration in those kinds of services. Presently, they are looking at what are the price components of a voucher, how does a voucher travel, who will it be tracked, how will it be paid, and all of those details. He stated that part of SAMHSA's intent is to expand the treatment capacity and recovery services capacity of the state, and also to insure choice and expansion of the number of faith-based organization that are eligible to provide clinical treatment and recovery support services at any jurisdiction. The application is due June 7th. A priority group of target populations has been identified and they are releases from the Adult Correctional Institute (ACI), releases from the Rhode Island Training School and adults whose children are in danger.

Craig stated that this is the major initiative of SAMHSA under President Bush, and it is the first time in the history of SAMHSA that the Executive Office has put money behind drug treatment.

Reed Cosper made a motion to provide a letter of support from the Council. The motioned was seconded, all were in favor and the motion was carried.

Craig added that this component would be a positive addition to the existing system because aftercare and recovery is an area that has never been a funded area.

Richard Leclerc asked how much money is being solicited. Charles stated that the working number is around 6 million because there are a number of fixed services in the administrative side that cannot be any more than 15 percent of the award; therefore they are pricing the administrative side first.

Craig commended those organizations and individuals who participated in Alcohol Awareness Month. The month was concluded with a ceremony at the State House conducted by the First Lady, Mrs. Carcieri, in which she initiated a program called Families Guiding Families.

Craig announced that May is Mental Health Month and there is a whole calendar of events.

Craig announced that everyone should ***"Save the Date" Saturday, September 29, 2007 for Recovery Month*** at WaterFire in Providence.

UPDATES FROM DCYF

Janet Anderson reported that both DCYF and MHRH is working with the assumption that the proposal to transfer the 18-21 year olds out of the DCYF system into MHRH will pass. However, DCYF has been given a charge to create another way of saving the money that is indicated to be saved with that change.

DCYF is also working on some major system redesign which includes the following:

- Utilizing the Organized System of Care Report
- Family and Community Care Partnerships
    - Final Draft of Concept Paper will be posted on DCYF website
    - Final community forum will be conducted end of May with closing conversations
    - RFP issued in June
    - Utilizing Positive Educational Partnership Grant for wrap around process

The DCYF budget included a managed care initiative to move a number of RITECare services that have been carved out into managed care. DHS and a team from DCYF have been looking at moving ahead on that initiative.

DCYF is designing a Rhode Island version of a care-management entity which is based on best practice models in the county to manage the highest and most complicated kids in the system to help bring them down through a wrap-around process to be back in the community in Rhode Island at the lowest level of care.

Janet stated that she will continue to update on the foregoing issues which have all been full presentations at previous meetings and references can be made to materials in their files from those meetings.

Janet reported that the Positive Educational Partnership is moving ahead, and they are in the implementation year. Janet stated that it is significant children's behavioral health work in terms of system's change and would like to do a presentation to the Council at an upcoming meeting.

Janet reported that the medical boarder beds are down by 50 percent since the implementation of the emergency services network. This dramatic change allows kids to be seen by child and family competent clinicians, and prevents the kids from getting stuck in medical hospitals needing psychiatric care.

Jeanne Smith added that at last month's meeting Dr. Colleen Carone presented data to the Council and at that time there were some comments and questions on the behavioral health data which she is interested in addressing via e-mail through Corinna Roy at croy@mhrh.ri.gov

BEHAVIORAL HEALTH DATA ELEMENTS SUBCOMMITTEE

Mitch Henderson distributed and reviewed the ***Council Dashboard Example (See Attachment II).*** He announced that the next meeting of the subcommittee will be held at DCYF on May 24 at 1:30 p.m. to review the DCYF material. Mitch added that they will need some additional input from the Department of Corrections (DOC). Mitch explained that the dashboard example is a prototype and summary of information that will need to be refined.

OLD/NEW BUSINESS

Corinna Roy stated that members will receive a notification via e-mail regarding the following two announcements: She announced that there has been a Mental Health Block Grant increase of 13.1 percent or approximately $182,000 which will require amendment and submission to the Council for review and comment within the next two weeks. Corinna also announced there will be a block grant site visit on Wednesday, June 20 from 1 p.m. to 3 p.m. in Barry Hall Room 126 which will consist of meetings with various consumer groups including the Mental Health Planning Council. Corinna stated that she would appreciate as many people as possible to be available for those meetings.

Corinna stated that the PATH RFP was completed and approved and is ready to go to Purchasing, but has been delayed due to some processing issues that exist for 2008 funding. She will update the Council accordingly.

Richard Leclerc mentioned that Mitch Henderson has been selected as a representative at the SAMHSA Planning meeting in Washington at the end of May. Corinna Roy and Jeanne Smith will also be attending those meetings.

Wendy Looker announced that Wednesday, June 6th is the Annual Legislative Day at the Rhode Island State House from 2:30 p.m. to 5 p.m. with guest speakers, and advocacy workshops. Nominations for awards need to be submitted to Jim Gillen by May 18, 2007.

ADJOURNMENT AND NEXT MEETING

There was no further business. Upon motion made and seconded, the meeting adjourned at 3:10 p.m. The next meeting of the Council is scheduled for **Thursday, June 14, at 8:30 a.m. in the first floor Conference Room 126 at the Barry Hall Building.**

Minutes respectfully recorded and written by:
Mary Ann Nassa
Secretary, Governor's Council on Behavioral Health

Attachment I: Program Update - Managed Care Options for Medicaid Adults in Rhode Island as of May 8, 2007
Attachment II: Council Dashboard Example